

Appendix 8

Family Questionnaire (Child Risk Assessment)

DEPARTMENT OF HEALTH AND FAMILY SERVICES

Division of Health

DOH 1118 (3/98)

STATE OF WISCONSIN

☞ = INITIAL SCREENING QUESTIONS

FAMILY QUESTIONNAIRE

A. GENERAL INFORMATION

1. Mother's Name and Address: *[Please print.]*
 Mother's Last Name First Middle
 Street Address
 City State Zip Code
2. Mother's date of birth: _____
- ☞ 3. Mother's age: _____ < 18 = (70)
 18 - 20 = (15)
4. Mother's Medicaid ID#: _____
5. HMO Name: _____
6. Primary Care Doctor/Clinic Name(s): _____

 If none or unable to answer = (10)
7. Infant's Name: _____
 Infant's Sex:
☐ Female
☐ Male
- ☞ 8. Birth Weight: _____
 If very low birth weight < 3.3 lbs. (1500 grams) = (70)
 If low birth weight < 5.5 lbs. (2500 grams) = (30)
 If birth weight > 10 lbs. (4540 grams) = (10)
- ☞ 9. Birth Date: _____
 If pre-term (gestational age < 37 weeks) = (70)
10. Home telephone number: _____
☐ No phone, or phone is often disconnected. = (15)
11. How can we contact you? _____

12. Are other agency staff visiting your home?
☐ No
☐ Yes
 If yes, please list if known: _____

B. EMPLOYMENT

1. Are you employed?
☐ No
☐ Yes
 If yes, what is your occupation? _____

2. If you are employed, how many hours do you usually work in a week? _____
3. What shift? (days, evenings, nights) _____
4. Do you feel your child care arrangements are safe and nurturing?
☐ No = (15)
☐ Yes
5. If returning to work/school, when will you go back? _____
- ☞ 6. What was the last grade you finished? _____
 8th grade or less = (40)
 > 8th grade but < 12th grade = (15)
7. What are your sources of income? *(Please check all that apply.)*
☐ Parents
☐ Job
☐ Partner/spouse
☐ Unemployment benefits
☐ Child support payments
☐ Other: _____

Key: > = greater than
 < = less than

Points (subtotal) _____

Appendix 8 (Continued)

C. FAMILY FUNCTIONING

1. Are you:
 - ☐ Married
 - ☐ Single (includes, never married, separated, divorced, widowed) = (15)
2. Do you speak English?
 - ☐ Very well
 - ☐ A little = (10)
 - ☐ Not at all = (15)
3. Do you read English?
 - ☐ Very well
 - ☐ A little = (10)
 - ☐ Not at all = (15)
4. If of school age now, are you enrolled and do you attend school regularly?
 - ☐ No = (10)
 - ☐ Yes
 - ☐ I am working on GED or have completed it
 - ☐ I have dropped out = (10)
5. Have you in the past, or are you currently, receiving special or exceptional education services?
 - ☐ No
 - ☐ Yes = (10)
6. How many children do you have? _____
 - If first child = (10)
 - If > 4 children = (40)
 - If > 2 children and mother is < 18 = (40)
7. Within the last 12 months, have any of your children been taken away from you?
 - ☐ No
 - ☐ Yes
 - If yes, how many? _____ = (40)
8. Where do you live?
 - ☐ House/Mobile Home
 - ☐ Apartment Mobile Home
 - ☐ With friends = (10)
 - ☐ With other family members = (10)
 - ☐ Homeless (including shelter, hotel/motel) = (70)
 - ☐ Other, specify: _____
9. Who is currently living in your home?

Name	Age	Relationship
10. Where you live now, do you have the following?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/> Running water
<input type="checkbox"/>	<input type="checkbox"/> Hot water
<input type="checkbox"/>	<input type="checkbox"/> Working appliances (stove, refrigerator)
<input type="checkbox"/>	<input type="checkbox"/> Working bathroom/bathing facilities
<input type="checkbox"/>	<input type="checkbox"/> Working smoke detector
<input type="checkbox"/>	<input type="checkbox"/> Working fire extinguisher

Each No = (5) Total points _____
11. Is there chipping paint inside/outside your home?
 - ☐ No
 - ☐ Yes = (10)
12. How many times have you moved in the last year? _____

> 2 times = (20)
13. Do you think you will need to move in the next 12 months?
 - ☐ No
 - ☐ Yes
14. How long have you been living in the present neighborhood? _____
15. What do you think of your neighborhood?
 - ☐ It's a good place to live
 - ☐ It's an okay place to live
 - ☐ It's a bad place to live
16. What is the best thing about your neighborhood? _____
17. What is the worst thing about your neighborhood? _____
18. In the past two years, has your neighborhood become:
 - ☐ A better place to live
 - ☐ Stayed the same
 - ☐ A bad place to live

Key: > = greater than
 < = less than

Appendix 8 (Continued)

19. Do your children have a safe play area both inside and outside the home?
☐ No to either = (5)
☐ Yes
20. If not at home, where else can they play? *[Please check all that apply.]*
☐ Relatives ☐ Nowhere = (15)
☐ Park ☐ School playground
☐ Community Center ☐ Other: _____
21. Have you witnessed acts of violence in your neighborhood? If so, please describe these acts and the impressions they had on you:

22. Does your family own an automobile?
☐ No
☐ Yes
23. If yes, what is the condition of the automobile?
☐ Good
☐ Average
☐ Below Average
24. If you do not have an automobile, how do you get around?
☐ Get a ride from friends/relatives
☐ Use public transportation
☐ Walk
☐ Other: _____
25. How often do you have problems getting transportation?
☐ Never
☐ Occasionally
☐ Most of the time = (10)
26. If you use a car, does everyone use car seats or seat belts?
☐ Always
☐ Sometimes
☐ Never = (5)
 Explain: _____

D. HEALTH

1. Where do you go for your regular health care (e.g., checkups, shots)?
☐ Family doctor/primary care provider/clinic
☐ Emergency room = (10)
☐ Other: _____
2. Have any of your children been hospitalized in the past 6 months?
☐ No
☐ Yes = (10)
 If yes, for what types of problem(s):

3. Have your children between 6 months and 6 years of age been tested for lead poisoning?
☐ No = (5)
☐ Yes
☐ Don't know = (5)
☐ Not applicable *(Skip to #6)*
4. If yes, have you received the results?
☐ No = (5)
☐ Yes
5. If the results require follow-up, has this occurred?
☐ No = (5)
☐ Yes
6. Do you have a record of your children's immunizations?
☐ No = (5)
☐ Yes
7. If your child(ren) are 3 years or older, are they seeing a dentist?
☐ No = (5)
☐ Yes
☐ Not applicable
8. How many months pregnant were you when you started seeing a medical provider (doctor, nurse practitioner, nurse midwife) for prenatal care?
 _____ weeks or _____ months
 13-15 weeks = (5) 15-23 weeks = (10) > 24 weeks = (20)
9. Did you receive prenatal care coordination services during this pregnancy?
☐ No
☐ Yes = (70)

Key: > = greater than
 < = less than

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- 10. How was your health during this pregnancy?**
☐ Fine, no problems
☐ Some problems (e.g., nausea, tiredness)
☐ Serious problems (e.g., high blood pressure, diabetes) = (10)
 Explain: _____
- 11. Did your baby stay in a "special care" nursery for more than one day?**
☐ No
☐ Yes = (10)
 If yes, how many? _____
- 12. Was this pregnancy:**
☐ Planned
☐ Unplanned = (5)
☐ Result of sexual assault = (40)
- 13. How do you feel now that the baby is born?**
☐ Happy
☐ Unsure--a little bit happy, a little bit unhappy = (10)
☐ Very upset about it = (20)
- 14. How does the father of the baby (or your partner) feel about the newborn?**
☐ Happy
☐ Unsure--a little bit happy, a little bit unhappy = (10)
☐ Very upset about it = (20)
- 15. Do you have any history of prenatal or postpartum depression, raging, or "scary" thoughts about the baby?**
☐ No
☐ Yes = (40)
- 16. Do you plan to have another baby?**
☐ No
☐ Yes
 If yes, how soon? _____
- 17. Are you currently using birth control?**
☐ No
☐ Yes
- 18. Do you understand how to use the product?**
☐ No = (5)
☐ Yes
- 19. Have you experienced any problems getting the necessary supplies, medication or services?**
☐ No
☐ Yes = (5)
- 20. Do you, or your children receive SSI benefits or special services for a health problem?**
☐ No
☐ Yes = (20)
 If yes, who? _____
 What services? _____
 If receiving mental health related services = (50)
- 21. Are you or your children in a WIC Program?**
☐ No
☐ Yes
 If yes, where? _____
- 22. How are you currently feeding your baby?**
☐ Breast-feed
☐ Bottle feed
☐ Both breast and bottle
- 23. At what age do you plan to start feeding cereal/baby food to your new baby?**
☐ Birth-3 months = (5)
☐ 4-6 months
☐ I don't know = (5)
- 24. Are any of your children on a special diet or receiving special foods or drinks?**
☐ No
☐ Yes = (5)
 If yes, what? _____
- 25. Do you or your children ever eat non-food items, (e.g., dirt, sand, starch, paint chips)?**
☐ No
☐ Yes = (20)
- 26. Do you sometimes run out of food before you are able to buy more?**
☐ No
☐ Yes = (10)

Key: > = greater than
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Appendix 8 (Continued)

F. PARENTING ATTITUDES/SKILLS

- 1.** How do you feel about the way you were raised as a child?
- ☐ Very positive: I had a happy childhood: my parents were very caring
 - ☐ Okay; my parents tried to do their best: parents caring
 - ☐ Negative: I received no nurturing = (10)
 - ☐ Very negative. I was punished frequently and received little or no nurturing = (40)
- 2.** If you plan to parent differently than you were raised, how much support/encouragement will you get from your family/friends?
- ☐ A lot
 - ☐ A little
 - ☐ Very little = (10)
 - ☐ None = (20)
- 3.** When you want advice about parenting, who do you go to? *[Please check all that apply.]*
- ☐ Parents
 - ☐ Friends
 - ☐ Doctor/nurse
 - ☐ Community "helping organizations"
 - ☐ I don't have anyone to ask = (10)
 - ☐ "It comes naturally" = (10)
 - ☐ Grandparents/family
 - ☐ Father of the child/partner
 - ☐ Books/magazines
- 4.** Do you ever feel your infant cries or is demanding "on purpose" or just to "irritate you"?
- ☐ No
 - ☐ Yes = (40)
- If yes, please explain: _____
- 5.** At what age do you think your baby will:
- ☐ Be potty trained _____
 - ☐ Sleep all night _____
 - ☐ Begin to walk _____
- If answer is unrealistic = (15)
- 6.** Do you have an adequate supply or access to toys, books, games, or other play equipment?
- ☐ No
 - ☐ Yes
- 7.** When your children are playing or having fun, do you join them?
- ☐ Most of the time
 - ☐ Occasionally = (5)
 - ☐ Rarely = (10)
- 8.** How helpful is the child's father (or your partner) in raising this child and other children in your household?
- ☐ Very helpful
 - ☐ Helps when requested to help
 - ☐ Not helpful = (10)
- 9.** Finish this sentence.
I think my/our children are: _____
- _____
- _____
- Use of strong negatives such as, interfere with my activities, too demanding, too much work, ugly, stupid, bad.* = (20)

F. TOBACCO, ALCOHOL AND OTHER DRUGS

- 1.** Do you or anyone else in your household smoke?
- ☐ No
 - ☐ Yes
- 2.** If yes, do you have "rules" governing when and where not to smoke?
- ☐ No = (20)
 - ☐ Yes
- I need to ask you a few questions about drinking and drug use. It will help us take better care of you and your children. Be sure to include beer, wine and liquor in your answers to these questions.*
- 3.** How many drinks does it take to make you feel high? _____ > 2 = (20)
- ☐ I never drink
- 4.** How much can you hold? _____ > 2 = (20)
- ☐ I never drink
 - ☐ I don't know
- 5.** Have people annoyed you by criticizing your drinking?
- ☐ No
 - ☐ Yes = (20)
 - ☐ I never drink

Key: > = greater than
< = less than

5

Points (subtotal) _____

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6. Have you ever felt you ought to cut down on your drinking?
- ☐ No
- ☐ Yes = (20)
- ☐ I never drink
7. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?
- ☐ No
- ☐ Yes = (20)
- ☐ I never drink

8. In the past 12 months, have you injected a non-prescribed drug or used any other street drugs (e.g., marijuana, hash, cocaine, heroin, crack, amphetamines)?
- ☐ No
- ☐ Yes = (70)

9. Does anyone who is involved in caring for your children abuse alcohol or other drugs?
- ☐ No
- ☐ Yes = (20)
- If yes, explain: _____

G. PERSONAL SUPPORT/COPING SKILLS

1. How do you deal with stress and anger? *[Please check all that apply.]*
- ☐ Talk it out
- ☐ Calm down by taking a walk, doing some activity
- ☐ Not talk about it at all = (5)
- ☐ Take it out on somebody by yelling = (5)
- ☐ Get violent (e.g., hitting, threatening with object or weapon) = (50)
- ☐ Have a drink or get high to calm my nerves = (20)
- ☐ Other: _____

2. How does the father of the baby (or your partner) deal with stress and anger? *[Please check all that apply.]*
- ☐ Talk it out
- ☐ Calm down by taking a walk, doing some activity
- ☐ Not talk about it at all = (5)
- ☐ Take it out on somebody by yelling = (5)
- ☐ Get violent (e.g., hitting, threatening with object or weapon) = (50)
- ☐ Have a drink or get high to calm his nerves = (20)
- ☐ Other: _____

3. Have you, or your children, ever been emotionally or verbally abused by the father of the baby, your partner, or someone close to you?
- ☐ No
- ☐ Yes = (20)

4. Does the father of the baby (or your partner) physically, verbally, or emotionally abuse you or your children?
- ☐ No
- ☐ Yes = (70)

5. Have you or other household members been raped or forced to have sex against your/their will?
- ☐ No
- ☐ Yes = (30)

6. Does the abuser(s) still have access to you or your children?
- ☐ No
- ☐ Yes = (40)

7. Has anyone in your immediate household (parent, spouse, partner, sibling) been incarcerated/jailed for a crime in the past year or more than 3 times in the past 5 years?
- ☐ No
- ☐ Yes = (40)

8. Are you afraid of the father of the baby, your partner or anyone else in your household?
- ☐ No
- ☐ Yes = (20)

9. Is there a gun in your home?
- ☐ No
- ☐ Yes = (10)

10. If yes, are the guns unloaded and stored in a locked place?
- ☐ No = (15)
- ☐ Yes

11. How many people do you know well enough to visit with in your neighborhood?
- _____ = (5)
- ☐ None

12. How often do you spend time with friends or relatives?
- _____ = (10)
- ☐ Never

Key: + = greater than
- = less than

Appendix 8 (Continued)

- 13.** Do you have someone you can talk with when you need to?
- ☐ No = (20)
- ☐ Yes

- 14.** Do you find yourself feeling lonely?
- ☐ Quite often
- ☐ Sometimes
- ☐ Almost never

- 15.** Is there anyone you can count on in case of an emergency?
- ☐ No = (10)
- ☐ Yes

- 16.** Is there someone who could help you for as long as you needed their help?
- ☐ No
- ☐ Yes

- 17.** Are you known or do you think of yourself as a resource to others?
- ☐ No
- ☐ Yes

- 18.** How often do you go to neighborhood activities such as spiritual ceremonies, support groups or "club" functions?
- ☐ Never = (5)

- 19.** How would you describe yourself to someone who does not know you?

- 20.** Does your family have special traditions that they observe?

- ☐ No
- ☐ Yes
- If yes, explain:

- 21.** Tell me about your family's strengths.

- ☐ None = (10)

- 22.** Which of these things worry you a lot? *[Check the ones that are big problems.]*

- ☐ Money problems = (2)
- ☐ Transportation = (2)
- ☐ My job = (2)
- ☐ My partner's job, or unemployment = (2)
- ☐ Caring for this baby/my other children = (2)
- ☐ Housing problems/getting evicted = (2)
- ☐ Getting child care = (2)
- ☐ My physical or mental health/safety = (2)
- ☐ My drinking/drug use = (2)
- ☐ My partner's drinking or drug use = (2)
- ☐ My relationship with my partner = (2)
- ☐ My child's relationship with his/her father = (2)
- ☐ My partner is in jail = (2)

- 23.** Would you like more help or information with any of these things?

- ☐ Discipline
- ☐ Child development
- ☐ Parenting skills
- ☐ Playing with your children
- ☐ Health Issues
- ☐ Employment Training
- ☐ Coping with stress
- ☐ Family planning/Pregnancy prevention
- ☐ Community resources for parents

Staff Signature/Assessment Date

Staff Signature/Reassessment Date

Key: > = greater than
< = less than

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Points (rubric/s) _____
Total roll pages: _____